

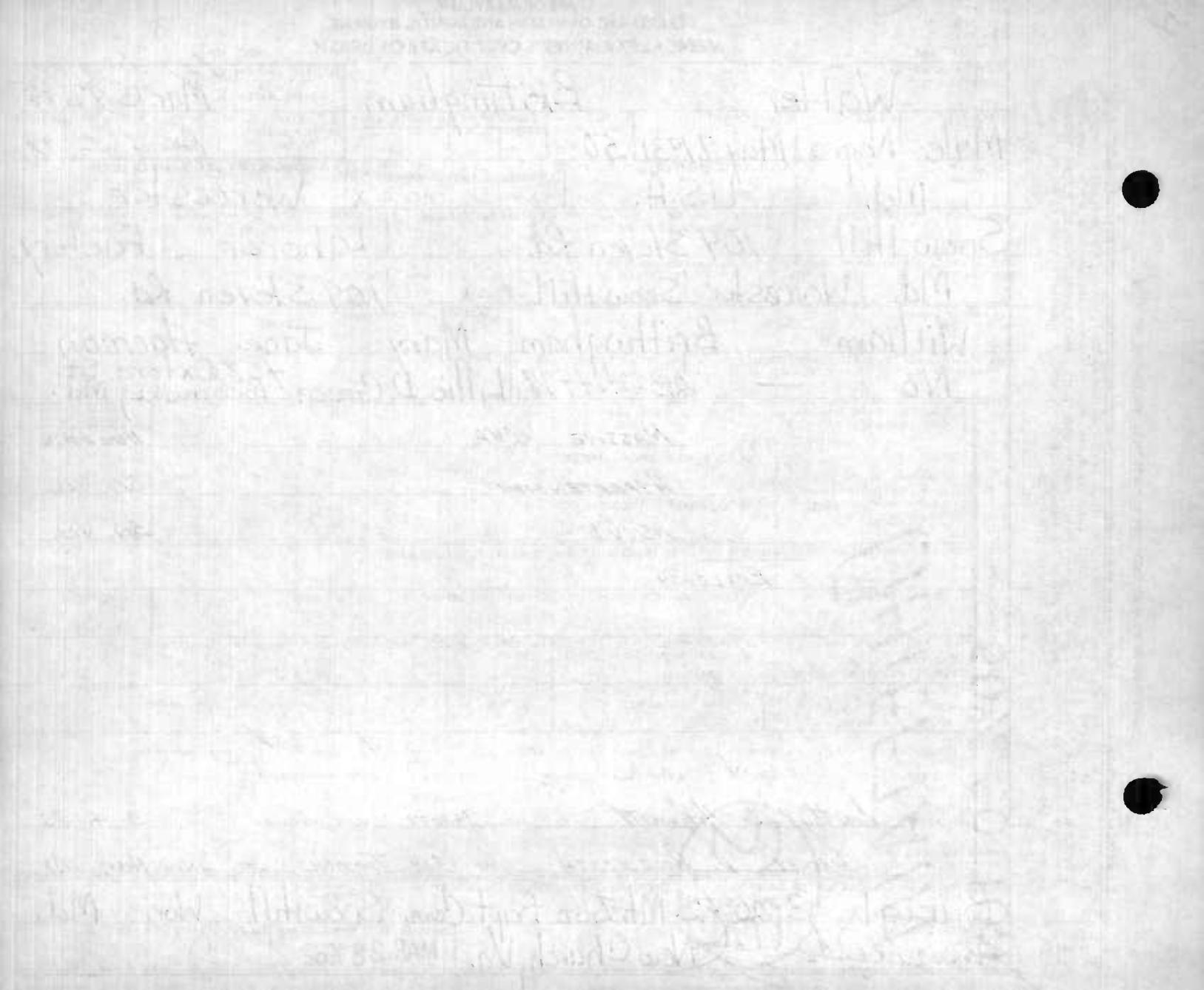
TO MEDICAL EXAMINER THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR PAGES. TO FUNERAL DIRECTOR: PAGE 7 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS (301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3208243

1. DECEASED NAME (TYPE OR PRINT)	FIRST Walter	MIDDLE	LAST Brittingham	2a. DECEASED KNOWN OF DEATH ESTIMATED MONTH DAY YEAR	2b. HOUR Mar. 15 1982 8:45 AM	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR May 7 1931 50	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS	9. IF HOURS HOURS
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	11. CITIZEN OF WHAT COUNTRY? U.S.A.	12. MARRIED WIDOWED	13. NEVER MARRIED DIVORCED	14. BALTIMORE CITY OR COUNTY OF DEATH Worcester	15. DATE PRONOUNCED DEAD Mar. 15 1982 9:00 AM	
10. CITY OR TOWN OF DEATH Snow Hill	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN A NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) 109 Steven Rd	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY Factory			
13a. STATE Md.	13b. COUNTY Worcester	13c. CITY OR TOWN Snow Hill	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 109 Steven Rd.		
14. FATHER'S NAME William	MIDDLE	LAST Brittingham	15. MOTHER'S MAIDEN NAME Mary Jane Harmon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO KNOWN) No	16b. SOCIAL SECURITY NO. 213-24-4478	17. INFORMANT Lillie D. Green	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CVA 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) HYPER TENSION DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD DUE TO, OR AS A CONSEQUENCE OF SEV. YRS. SEV. YRS.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). EPILEPSY						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Dorothy C. Holzworth	TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) DOROTHY C. HOLZWORTH	ADDRESS 309 Tiemann St. Snow Hill, Md.	DATE SIGNED 3-18-82				
22b. FUNERAL CREMATION REMOVAL SPECIAL Burial	22c. DATE 3-20-82	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Bapt. Cem.	23d. LOCATION CITY OR TOWN Snow Hill	24. FUNERAL DIRECTOR NAME Dorothy C. Holzworth	25a. DATE REC'D. BY REGISTRAR MAR 23 1982	25b. REGISTRAR'S SIGNATURE Dorothy C. Holzworth
DPHMH-17 (VR A15 ME (5)) 15M 7/77						

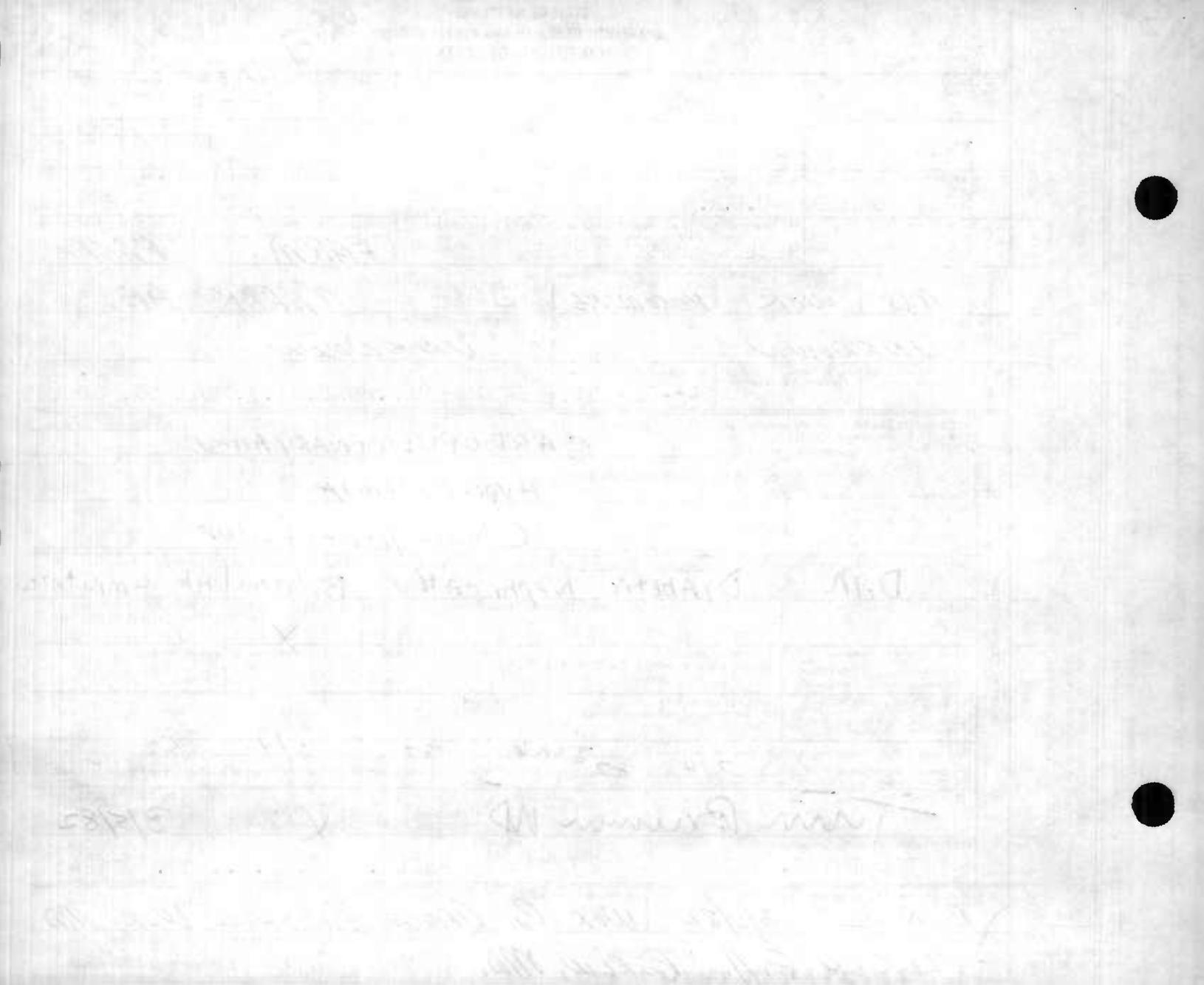


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208244	
												REG. NO.	
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST EDWARD	MIDDLE	LAST CROWDER	2a DATE OF DEATH	MONTH 3-4-82	DAY	YEAR	2b HOUR 9:40P M		
3 SEX MALE	4 RACE BLACK	5. DATE OF BIRTH MONTH 10			DAY 1	YEAR 1904	6 AGE (IN YEARS LAST BIRTHDAY)	77	IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH WORCESTER COUNTY			MD.					
10 CITY OR TOWN OF DEATH BERLIN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARM			12b KIND OF BUSINESS OR INDUSTRY AGRIC.						
13a STATE MD	13b COUNTY WOR	13c CITY OR TOWN POKOMAKE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS CLARK AVE.							
14 FATHER'S NAME UNKNOWN	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME UNKNOWN										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO 16b SOCIAL SECURITY NO 244-32-6517	17 INFORMANT	18a ADDRESS MD. 21811										
18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5850</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HyperKalemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Renal Failure</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) D.M. <u>Diabetic Nephropathy</u> <u>Bilateral AK Amputation</u>													
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> , 19 <u>82</u> , to <u>3/4</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>3/4</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Timothy Bainum MD</u>	DEGREE MD	22c ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 3/15/82								
22e PHYSICIAN'S NAME (TYPE OR PRINT) TIMOTHY E. BAINUM	22f ADDRESS 16th & PHILA. AVE., O.C., MD. 21842												
23a BURIAL, CREMATION, REMOVAL SPECIES BURIAL	23b DATE 3/11/82	23c NAME OF CEMETERY OR CREMATORIAL WOR. C. Cemetery			23d LOCATION CITY OR TOWN SANDY HILL WOR. MD			COUNTY			STATE		
24 FUNERAL DIRECTOR NAME OLLRICH F. A.	ADDRESS BERLIN, MD.				25a DATE REC'D. BY REGISTRAR MAR 15 1982			25b REGISTRAR'S SIGNATURE James J. Ollrich					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82	88245				
REG. NO.																	
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
EMMA			J.			FARRELL						3	3	82		8:17 P	
3 SEX		4 RACE		5 DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		WHITE		MONTH 6			DAY 22			YEAR 1897			84		YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		USA								WORCESTER							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY							
BERLIN		BERLIN NURSING HOME		BAR OWNER													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STREET ADDRESS					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
MD.		WORCESTER		OCEAN CITY			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			218 SOMERSET ST.							
14 FATHER'S NAME		MIDDLE		LAST			15 MOTHER'S MAIDEN NAME										
JESSE				TRUITT			LUCY			ANNE TRUITT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		214 34 7924					NADINE FARRELL PARKS										
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY												Cardiopulmonary arrest					
IMMEDIATE CAUSE (a)																	
7 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												Bilateral pneumonia					
DUE TO, OR AS A CONSEQUENCE OF (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												Cerebral vascular accident					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 6, 1982, to 3/3, 82, that (I) (we) last saw the deceased alive on 3/3, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED					
22b. SIGNATURE TIMOTHY E. BAINUM												22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) TIMOTHY E. BAINUM												22f. ADDRESS 16th & Phila. Ave, O.C., Md. 21842					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 3/5/82		23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL			23d. LOCATION TOWNSHIP			COUNTY			STATE				
24. FUNERAL DIRECTOR NAME Anne A. Burtay		ADDRESS 108 WILLIAMS ST. BERLIN, MD 21811					25a. DATE RECD'D BY REGISTRAR 3/5/82			25b. REGISTRAR'S SIGNATURE Anne J. Burtay							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR USES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 0 8 2 4 6											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR MONTH DAY YEAR								
Sidney Russell Fisher												<input checked="" type="checkbox"/> <input type="checkbox"/> MONTH DAY YEAR			2b. HOUR 3 28 1982 2 15 20 M								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR MONTH DAY YEAR						
MALE		Negro		4 12 05			87 yrs.			MONTHS		DAYS		HOURS		MIN.		5 28 1982 3 P.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?												8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Accomac, Va.		U.S.A.																		Worcester			
10. CITY OR TOWN OF DEATH Newark															11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY Worcester			13c. CITY OR TOWN Newark			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS P.O. Box 22			MD.								
14. FATHER'S NAME Matthew			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME Sarah			FRANCES			YOUNG								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. - - -			16c. PART 1 IMMEDIATE CAUSE (a) 4275 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			17. INFORMANT MAGGIE Fisher			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO - RESPIRATORY CESSATION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>HYPERTENSION</u> <u>PERIPHERAL VASC. DISEASE</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Dorothy C. Holzworth</u> M.D. TITLE (SPECIFY) EXAMINER'S NAME <u>DOROTHY C. HOLZWORTH</u> ADDRESS <u>309 Timmons St. Snow Hill, Md.</u>															DATE SIGNED <u>3-29-82</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/13/82			23c. NAME OF CEMETERY OR CREMATORIAL WMS. A.M.E. Cemetery			23d. LOCATION CITY OR TOWN Newark			23e. COUNTY Worcester			STATE Md.								
24. FUNERAL DIRECTOR NAME <u>Jolley Memorial Chapel</u>			ADDRESS Rt. 2, Jersey Rd.			25a. DATE REC'D. BY REGISTRAR APR 5 1982			25b. REGISTRAR'S SIGNATURE <u>Anne Jolley</u>														

2 25

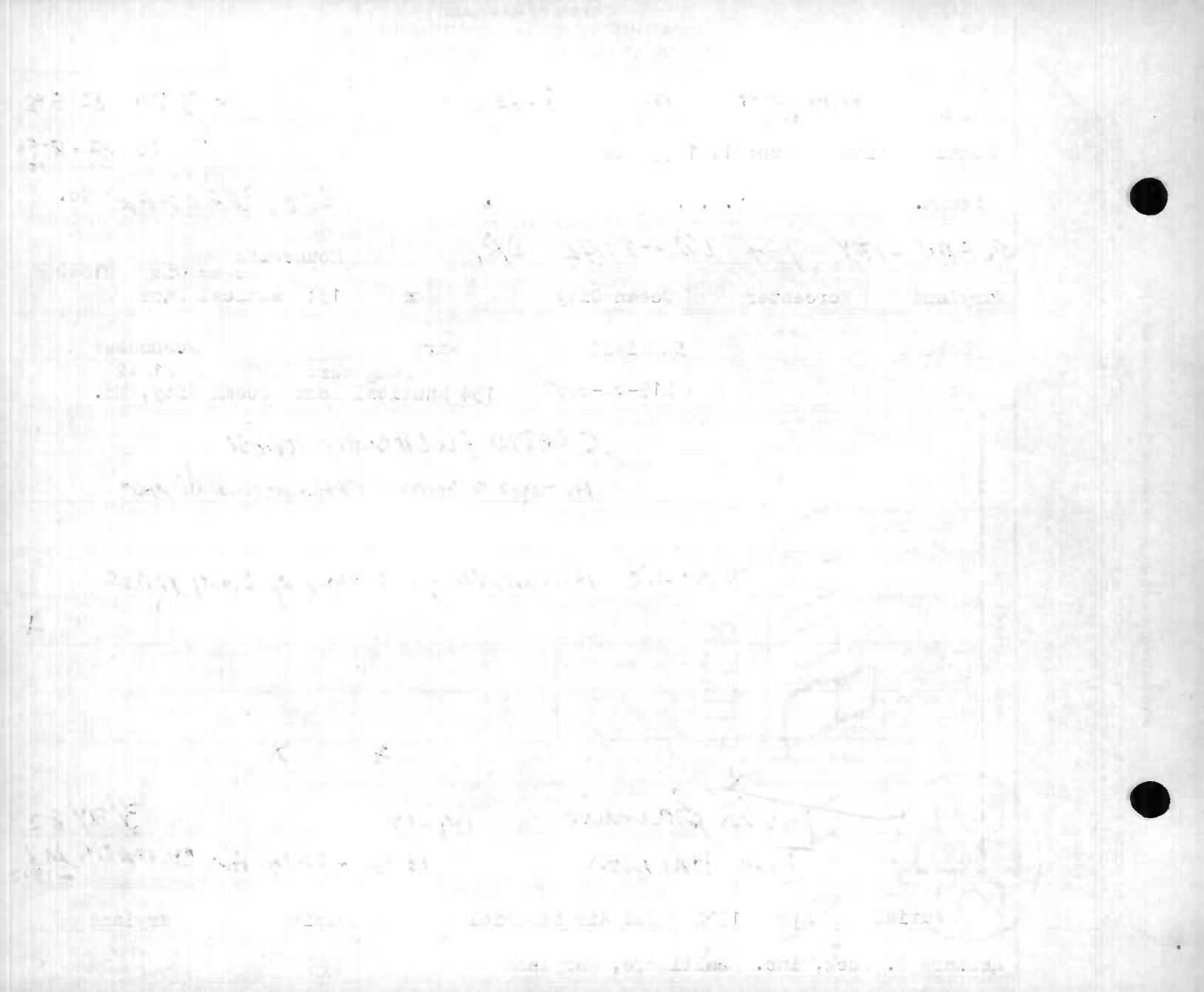
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 0 8 2 4 7

REG. NO.

1. FOR STATE REGISTRAR		2. DATE OF ESTI- MATED										2b. HOUR MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			<input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR MONTH DAY YEAR			
Margaret m. Gebauer										3 30 1982 5:00 AM					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR MONTH DAY YEAR	
Female		White		June 17 1895		86 yrs.						3 30 1982		2d. HOUR 8:56 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER Co. MD.							
Penns.		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
OCEAN CITY		134 NAUTICAL DR.										Housewife		Ocean City 21842	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		134 Nautical Lane			
Maryland		Worcester		Ocean City											
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		Fushouser			
Robert				Duffield		Mary									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Daughter:		ADDRESS		21842		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		219-20-9592		134 Nautical Lane		Ocean City, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART 1 DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY arrest</u>															
4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.															
DOUE TO, OR AS A CONSEQUENCE OF															
(b) <u>Arterio sclerotic cardiovascular disease</u>															
DOUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
<u>Thoracic Aneurysm; history of Lung mass</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		21d. LOCATION STREET		21e. CITY OR TOWN		20. AUTOPSY?					
		19								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21h. LOCATION STREET		21i. CITY OR TOWN		21j. COUNTY		21k. STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 16th & Phila. Ave. Ocean City, Md. 21842													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
Burial		Apr 2 1982		Bel Air Memorial		Belair		Maryland							
24. FUNERAL DIRECTOR NAME		ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland													
		25a. DATE REC'D. BY REGISTRAR APR 31 1982 Frances Jan Nathan													
		25b. REGISTRAR'S SIGNATURE													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 12 months after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be paged at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 2 4 8			
										REG. NO.			
1 - FOR STATE REGISTRAR			I. DECEASED NAME TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
			RUTH H. GRUVER						3/11/82		1:05 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE IN YEARS LAST BIRTHDAY		# UNDER 1 YEAR		# UNDER 24 HRS		
FEMALE		WHITE		6-11-1900			81		YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
MARYLAND		U.S.A.					WORCESTER COUNTY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BERLIN		BERLIN NURSING HOME			NURSE								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS			
13a. STATE MD.		13b. COUNTY WORCESTER		13c. CITY OR TOWN BERLIN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS BAY STREET, BERLIN, MD.				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
ALFRED HAYMAN			ADDIE PARKS										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
(IF YES, GIVE WAR OR DATES)			212-12-0487			BERLIN NURSING HOME, RT. 3, BOX 13,			BERLIN, MD. 21811				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)													
5850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (b)													
Hypernatremia													
DUE TO, OR AS A CONSEQUENCE OF (c)													
Chronic Renal failure													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from Jan 6, 1982, to 31, 1982, that (I) (we) last saw the deceased alive on 3/10, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 3/11/82			
22b. SIGNATURE T. Bainum MD										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			16th & PHILA. AVE, OCEAN CITY, M.D.							
TIMOTHY E. BAINUM, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
CREMATION		3/14/82		DELMARVA CREMATORIAL			LEWIS		DEL				
24. FUNERAL DIRECTOR NAME										24. DATE REC'D. BY REGISTRAR			
WILSON FUNERAL HOME										MAR 29 1982			
SALISBURY, MD.													
DHMH-16 25M (VRA 15, 4) 1/79													

1901-53/1/3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 (Rev. 1-1-74)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified since

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 2 0 8 2 4 9				
1 - STATE REGISTRAR				REG. NO.												
1 DECEASED NAME (TYPE OR PRINT)				FIRST			MIDDLE		LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR 4:30
ANNA									HILL			3 - 20-82				AM
3 SEX				4 RACE			5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS		
FEMALE				WHITE			MONTH 8 DAY 16 YEAR 09		72 YRS			MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			MD				
MD.				U.S.A.					WORCESTER							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
BERLIN				BERLIN NURSING HOME			Store Clerk									
13a. STATE MD.				13b. COUNTY Somerset			13d. INSIDE CITY LIMITS? No			13e. STREET ADDRESS ROUTE #1						
14 FATHER'S NAME John				15 MOTHER'S MAIDEN NAME Rosa						Tawes						
FIRST John			MIDDLE M.		LAST Webster											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS						
no				214-28-3688			BERLIN NURS. HOME, RT 3, B-13, BERLIN			MD. 21811						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Respiratory arrest				
DUE TO, OR AS A CONSEQUENCE OF (b)												Bilateral Bronchopneumonia				
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/19/82 to 3/20/82, that (I) (we) last saw the deceased alive on 3/19/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Tim Bainum, M.D.				DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/21/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 16th & Phila Ave Ocean City MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/23/82			23c. NAME OF CEMETERY OR CREMATORIUM Beechwood Cemetery			23d. LOCATION CITY OR TOWN Princess Anne, Somerset, Md.			COUNTY		STATE	
24. FUNERAL DIRECTOR James L. Hixman				ADDRESS Princess Anne, Md.			25a. DATE REC'D. BY REGISTRAR MAR 30 1982			25b. REGISTRAR'S SIGNATURE Frances Jan Nathan						

Photo credit

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Fairfax

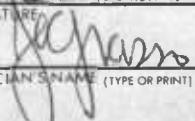
CH 100013

Санкт-Петербург

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

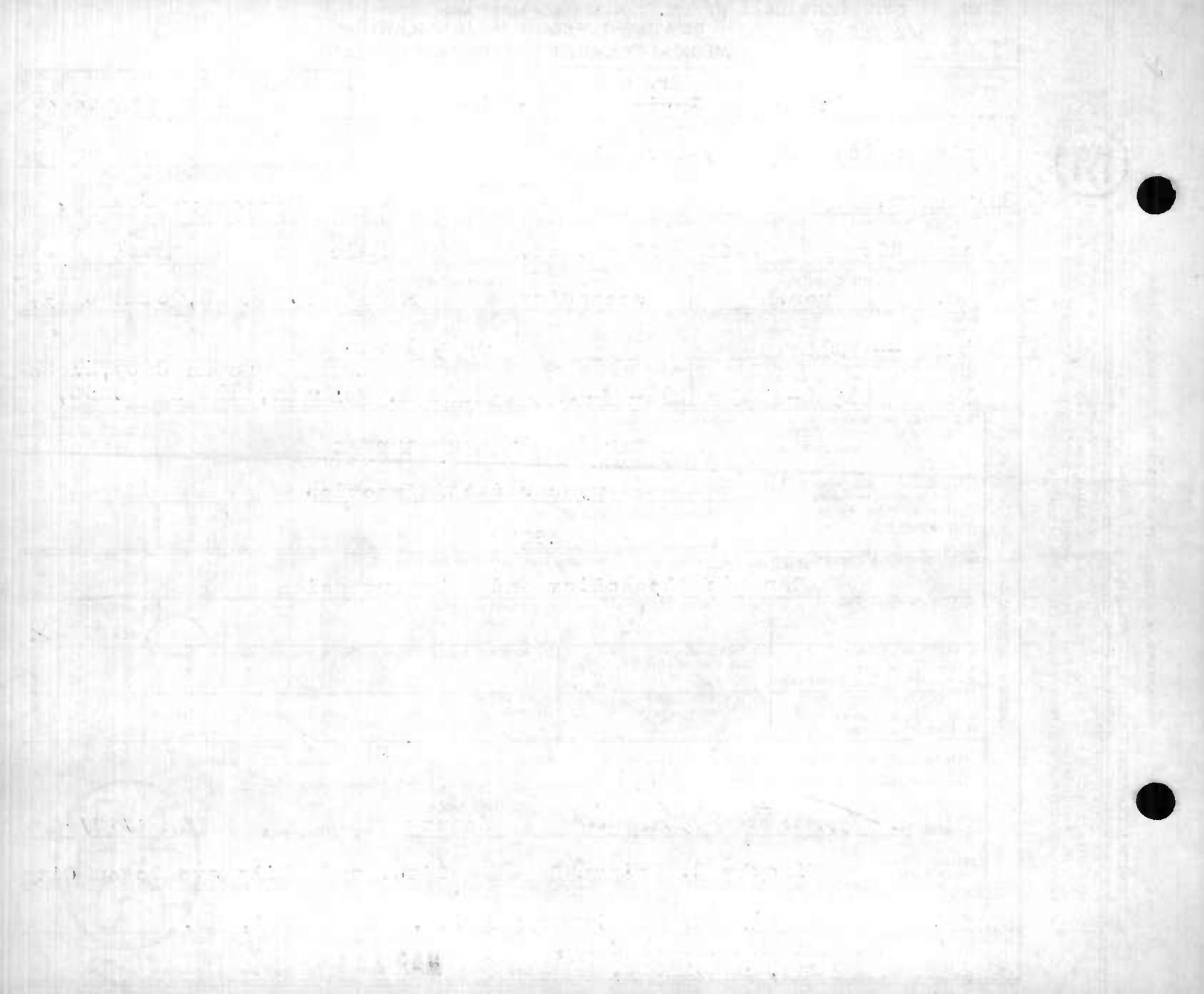
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												6208250						
1 - FOR STATE REGISTRAR											REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
TRYPHOSIA			FOSTER			JOHNSON						MARCH 21 1982			9:45 AM			
3. SEX		4. RACE		5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		BLACK		MONTH 4			DAY 13			YEAR 01			MONTHS 80		DAYS YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
CAMDEN, N.J.		U.S.A.		<input checked="" type="checkbox"/>			<input type="checkbox"/>			WORCESTER								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
SNOW HILL		BLAKE LANE										retired			laborer			
13a. STATE MARYLAND		13b. COUNTY WORCESTER		13c. CITY OR TOWN SNOW HILL			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ROUTE #3, Box Blake Lane								
14. FATHER'S NAME JAMES		MIDDLE		LAST BROWN			15. MOTHER'S MAIDEN NAME MARY			MIDDLE			LAST DINGLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-20-4605		17. INFORMANT Pete Johnson			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			ADDRESS 212 Green Street SNOW HILL, MARYLAND			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		
19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) (the hospital) attended the deceased from 274 19 8V, to 19, that (I) (we) last saw the deceased alive on 274 19 8V, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																		
22b. SIGNATURE 		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3/30/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/27/82			23c. NAME OF CEMETERY OR CREMATORIAL MT. WESLEY U.M. CEM.			23d. LOCATION CITY OR TOWN SNOW HILL			COUNTY		STATE WORCESTER MARYLAND					
24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL		ADDRESS RT. 2, JERSEY RD. SALISBURY, MARYLAND			25a. DATE REC'D. BY REGISTRAR APR 5 1982			25b. REGISTRAR'S SIGNATURE 										
DHMH-1650M7/77 (VRA 15 (4))																		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF BURIAL, CREMATION, OR REMOVAL. BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 8 2 5 1			
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR P.M.			
Richard Irvin					Irvin		McLaren			<input checked="" type="checkbox"/> 3 16 19 82		11:00			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR 8:10 a.m	
Male		white		Aug 28, 1917		64 yrs.						3 17 19 82			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		worcester County, MD.							
Baltimore, MD		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Ocean City		#111 136th. st.						Salesman		Real Estate					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21842					
Md.		wor.		oceanCity				111 136th St, Ocean City, MD							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Robert -- McLaren						Mary Irwin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Yes		1942-1945		218-03-6255		Jessie A. McLaren, 111 136th St,									
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiopulmonary arrest													
4100 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost:		DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction													
		DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).															
Chronic Alcoholism and hypertension															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. deputy						DATE SIGNED 3/17/82							
EXAMINER'S NAME (TYPE OR PRINT)		Timothy E. Bainum MD						ADDRESS 16th. and Phila ave Ocean City							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		3/20/82		New Cathedral Cem.		Baltimore, MD.									
24. FUNERAL DIRECTOR NAME		Schimunek Funeral Home, 3331 Brehms Lane, Baltimore, MD 21213						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
								MAR 22 1982		Gwen Jean Martin					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 2 5 2																
										REG. NO.																
1 - STATE REGISTRAR			2R. DATE OF DEATH MONTH DAY YEAR							2b. HOUR																
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		3 13 82		3:00P M															
CLARENCE J. Nibblett, Sr.																										
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN															
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER COUNTY		10. CITY OR TOWN OF DEATH BERLIN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Logger			12b. KIND OF BUSINESS OR INDUSTRY Logging							
13a. STATE MD.			13b. COUNTY WICOMICO			13c. CITY OR TOWN SALISBURY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1502 Arbutus Dr. Salisbury		14. FATHER'S NAME Samuel Nibblett			15. MOTHER'S MAIDEN NAME Mary Hall			16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17. ADDRESS Rt. 3, Box 1371 Mrs. Connie LeCates, Easton, Md. 21601							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES			16b. SOCIAL SECURITY NO. WW I			17. INFORMANT (daughter) ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21. DATE OF OPERATION								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			21. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21. DATE OF OPERATION								
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> , 19 <u>82</u> , to <u>3/13</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>3/12</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Timothy E. Bainum, M.D.			22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 3/14/82			22a. DATE OF OPERATION			22b. CONDITION FOR WHICH OPERATION WAS PERFORMED			22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TIMOTHY E. BAINUM, M.D.			22e. ADDRESS 16th & PHILA.AVE, OCEAN CITY, MD. 21842																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/16/82			23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery			23d. LOCATION CITY OR TOWN Salisbury, Wic. Maryland			24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, ADDRESS Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR MAR 19 1982			25b. REGISTRAR'S SIGNATURE James J. Hartman								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Please sign and return it to us.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 6 8566 4/26/82 8J

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 8 2 5 3

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
DOROTHY			SHREVE			3- 13-1982				11:50P			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		3- 5-1892		90 - 91		YRS		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		WORCESTER COUNTY MD.					
PENNSYLVANIA		U.S.A.											
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BERLIN		BERLIN NURS. HOME				HOUSEWIFE							
13a STATE DE MD						13b. COUNTY WOR		13c. CITY OR TOWN OCEAN CITY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 424 BAYERORE	
14 FATHER'S NAME FIRST LEONIDAS L.C. MIDDLE LAST FOX						15 IS MOTHER'S MAIDEN NAME FIRST ELIZZIE MIDDLE LAST KAHN						ADDRESS MARYLAND	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		18a APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
NO		579-28-9819		BERLIN NURS. HOME, RT. 3, BOX 13, BERLIN,									
18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292						cardiopulmonary arrest							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD							
						DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) cerebral vascular disease													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from 8/15, 1982, to 3/13, 1982, that (I) (we) last saw the deceased alive on 3/12, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Timothy E. Bainum, M.D.		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		22f. ADDRESS					
TIMOTHY E. BAINUM, M.D.						16th & PHILA.AVE, OCEAN CITY, MD. 21842							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
CREMATION		3-15-82		DELMARVA CREM		L ELLIES, SUESEY, DEL							
24 FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ULLRICH FUNERAL HOME		BERLIN, MD.				3/14/82		ULLRICH, SUESEY, DEL					

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 2 0 8 2 5 4						
1- STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST										2a. DATE KNOWN OF ESTI- DEATH MATED	2b. MONTH DAY YEAR	2b. HOUR 7:30 AM				
		ORIS ALLEN TRADER										<input checked="" type="checkbox"/>	March 21, 1982					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR 3-21 1982 8:44 AM				
male		white		May 13, 1917		64 yrs.		MONTHS		DAYS HOURS MIN								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Worcester						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Stockton		(residence) Stockton Road										barber						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
												Maryland	Worcester	Stockton	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	Route #1, Box 133A	
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		ADDRESS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.	17. INFORMANT		
		Oris		James		Trader		Minnie				yes WW2			218-05-8524	Irene Trader	Route #1, Box 133A Stockton, Maryland 21864	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1 DEATH WAS CAUSED BY: Coronary Occlusion																		
IMMEDIATE CAUSE (a) 4100												DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												(b)						
												DUE TO, OR AS A CONSEQUENCE OF						
												(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?						
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
		HOUR A.M. MONTH DAY YEAR		P.M.		19												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		STREET			CITY OR TOWN									
									COUNTY									
									STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER						
ACTUAL SIGNATURE <i>J. G. Santiano, M.D.</i>												DATE SIGNED 3-23-82						
EXAMINER'S NAME (TYPE OR PRINT)		J. G. Santiano, M.D.										ADDRESS 100 8th St. Pocomoke City, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION		CITY OR TOWN			COUNTY		STATE					
Burial		3/24/82		First Baptist Cemetery		Pocomoke		Worcester			Md.							
24. FUNERAL DIRECTOR		NAME <i>Scott Melton</i>		ADDRESS Pocomoke City, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
						APR 2 1982												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82 08255	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
RUBEN WINTERS						3 16 82			20 00 M		
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7a. IF UNDER 1 YEAR MONTHS DAYS	
Male		Black		NOV. 28 1913			68			IF UNDER 24 HRS MONTHS HOURS MIN	
YRS											
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH	
Md.		U.S.A.					WORCESTER MD.			Pocomoke	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
RT-1 Box 334											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Worcester		Pocomoke		YES <input type="checkbox"/>		RT-1 Box 334			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Sidney Waters		Laura Schoolfield			YES <input type="checkbox"/>		577-03800		3610-26 ST NE Peggy Davis - Washington, DC.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (d)			19. DUE TO, OR AS A CONSEQUENCE OF (b)		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4140		CHF			ASHD		1-2 DAYS				
Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause first					21. DUE TO, OR AS A CONSEQUENCE OF (c)		Sev. yrs.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
20a. MEDICAL CERTIFICATION		20b. DATE OF OPERATION		20c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20d. AUTOPSY?		20e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from FEB. 19 81 to DEC. 19 82, that (I) (we) lost saw the deceased alive on DEC. 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dorothy C. Holzworth		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 3-17-82				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dorothy C. Holzworth		22f. ADDRESS 309 Timmons St. Snow Hill, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-20-82		23c. NAME OF CEMETERY OR CREMATORIAL Trinity			23d. LOCATION CITY OR TOWN Pocomoke - Worcester, Md.		23e. COUNTY STATE		
24. FUNERAL DIRECTOR Reids E. Kurtz - Accomac, VA.		25a. DATE REC'D. BY REGISTRAR MAR 26 1982		25b. REGISTRAR'S SIGNATURE Helen							
ADDRESS											

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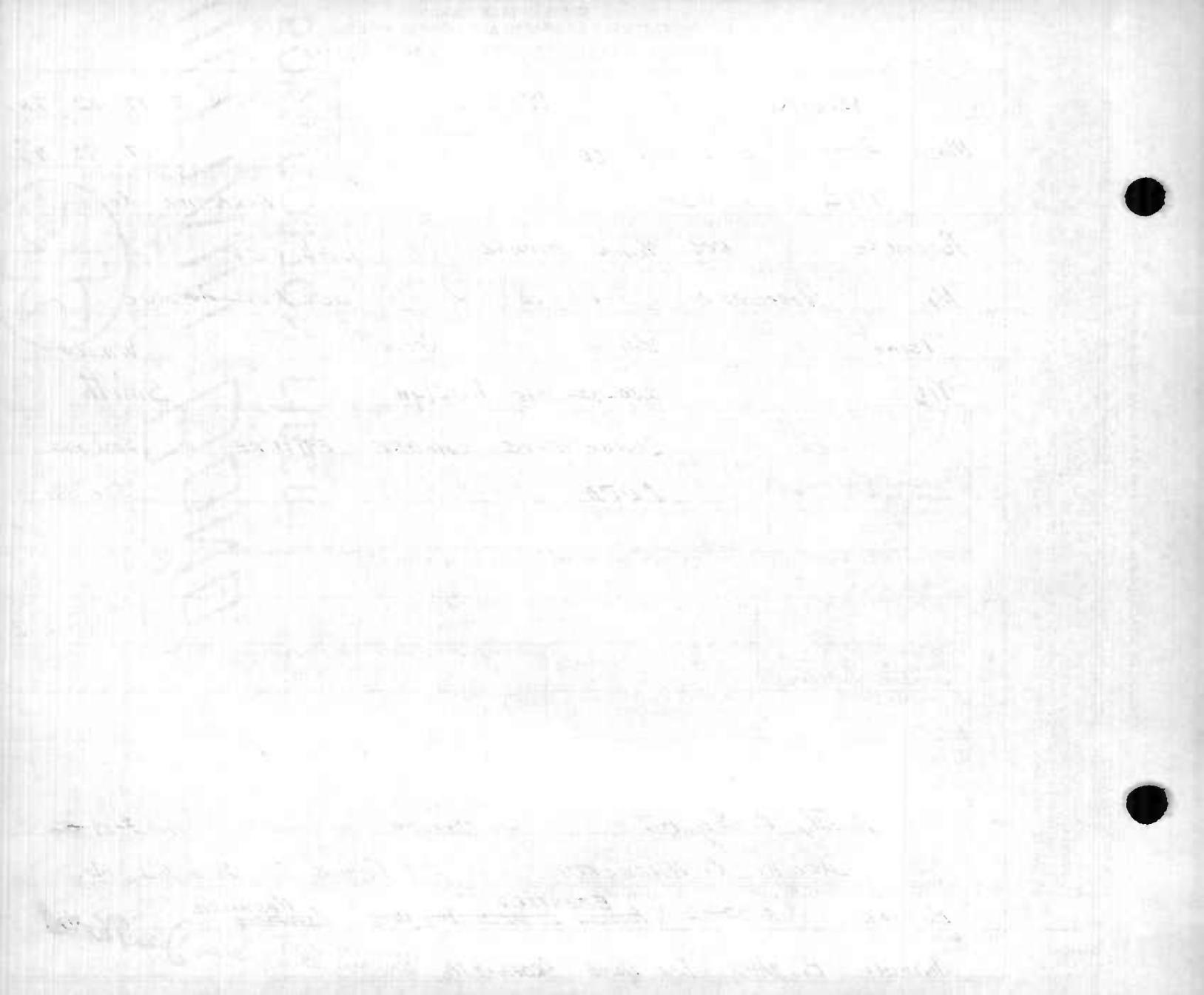
Wetlands and urban areas

the ~~university~~ - And - 200

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 OF YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08256							
1- STATE REGISTRAR			2. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR 3 17 1982									2b. HOUR 7A M							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 17 1982			2d. HOUR 11A M				
WILLIAM T. WATSON												9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER CO., MD.							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2d. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR 3 17 1982			2b. HOUR 7A M				
MALE		BLACK		10 7 1921		60 YRS.						2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 17 1982			2d. HOUR 11A M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER CO., MD.													
Md		USA																	
10. CITY OR TOWN OF DEATH DC		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 506 YOUNG AVENUE									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY					
35																			
13a. STATE Md		13b. COUNTY WORCESTER		13c. CITY OR TOWN POCOMOKE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 506 YOUNG AVENUE											
30																			
14. FATHER'S NAME FIRST ISIAH		MIDDLE		LAST WATSON		15. MOTHER'S MAIDEN NAME FIRST RECIE		MIDDLE		LAST WILSON		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-12-2015		17. INFORMANT ADDRESS Evelyn Smith		
30																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF 4960 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEV. HRS.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												SEV. YRS.							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> , and in my opinion																			
ACTUAL SIGNATURE <u>Dorothy C. Holzworth</u> M.D. <u>DECUTY</u> MEDICAL EXAMINER												DATE SIGNED <u>3-19-82</u>							
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS <u>309 Tiernan St. Snow Hill, Md.</u>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-27-82			23c. NAME OF CEMETERY OR CREMATORIAL EVENER			23d. LOCATION CITY OR TOWN <u>MARYLAND</u> COUNTY <u>ESSEX</u> STATE <u>MARYLAND</u>										
24. FUNERAL DIRECTOR NAME ANTHONY E. Ward			ADDRESS <u>Fun. Home Crisfield, Md.</u>									25a. DATE REC'D. BY REGISTRAR <u>JAN NATHAN</u> REGISTRAR <u>Frances</u> DATE <u>MAR 23 1982</u>							
BP																			
DHMH-17 (VR A15 ME (5)) 15M 2/80																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 2 0 8 2 5 1					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Robert									Williams			March		4	1982		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Male		Negro		May 4, 1914			67			U.S.A.		Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>			Worcester		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Snow Hill		423 Market St.										Laborer		Factory			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
Md.		Worcester					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		423 Market St.								
14. FATHER'S NAME		FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME						
Carey								Williams			Mary Jane Flingard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		218-16-7868		Evelyn Williams			Severe emphysema (respiratory failure)			423 Market St.				Snow Hill, Md.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) arteriosclerotic heart disease, peptic ulcer disease																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
19					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE C. STEGMAN MD.		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-9-82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. STEGMAN		22e. ADDRESS P.O. Box 40 Prince Anne Md															
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3-13-1982			23c. NAME OF CEMETERY OR CREMATORIAL Tull Cemetery			23d. LOCATION CITY, TOWN, COUNTY, STATE			25a. DATE REC'D. BY REGISTRAR MAR 16 1982						
24. FUNERAL DIRECTOR Name _____ James J. Seger		Address New Church, Va.									25b. REGISTRAR'S SIGNATURE Jane J. Seger						

